SITE VISIT SUMMARY REPORT
HCPCS CODING STANDARDIZATION PROJECT

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Prepared by

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and its Subcontractor
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1. PURPOSE OF REPORT

The HCPCS Standardization Project was initiated in July 1984 and represents a comprehensive effort to assess and improve the use and maintenance of HCPCS for Medicare Part B reimbursement. Project work has been proceeding concurrently on four task areas:

1. Development of an Index and an Index Update Methodology for HCPCS
2. Linkage of Part A Billing Data with Part B Data and Testing of Adaptors for DRG Formulation
3. Analysis of the Potential Impact of Use of ASA Anesthesia Codes for Reimbursement
4. Providing for a System for HCPCS Maintenance and Monitoring of HCPCS Usage

The present report represents an interim summary of observations and tentative conclusions and recommendations in the fourth task area above. This interim report is based on site visits conducted with six carriers. A separate report on each site visit was prepared, returned to the carrier for review, comment, and correction (see Appendix for copies of site visit reports). These site visits were carried out in order to document for each carrier the history of HCPCS implementation, to assess the coding workload for the carriers, collect any existing data concerning coding accuracy by carrier or provider staff, to develop a methodology for more fully assessing coding accuracy, to identify problems in HCPCS maintenance and usage, and to provide information used in addressing issues concerning anesthesia coding system alternatives (the third task area listed above).

The carriers selected for site visits were:

- CIGNA
- Blue Shield of Maryland
- Blue Shield of Florida
- Blue Shield of Indiana
- Washington Physicians Service
- Blue Shield of California

The site visit observations from these diverse carriers have been used to synthesize some general conclusions about HCPCS implementation, the diversity of usage among the carriers, HCPCS maintenance considerations, and methodological issues concerning HCPCS data quality assessment.

2. METHODOLOGY

Carriers were selected for site visits to represent a geographically dispersed sample, wide range of electronic media claims percentages, disparate pre-HCPCS coding systems, and a wide range of annual claims volumes. All selected carriers had implemented HCPCS at least six months prior to the site visit. A tentative list of candidate carriers was first screened by the HCFA Bureau of Program Operations, then the Regional Offices were contacted for concurrence, and then the carriers were contacted directly to arrange for the visit. Each carrier was provided with a copy of the "Comprehensive System Plan for HCPCS Code Standardization" (dated May 1, 1985) as background for the visit (see Appendix B). The site visit team consisted of two senior contractor staff and the HCFA project officer.

Exhibit A represents an agenda used for most site visits. The discussions required from 3-5 hours, depending upon the prior experiences of the carrier staff and their addition of topics to the agenda. The site visit team utilized the check list which appears in Exhibit B to review whether all items of concern to the study had been covered. However, an open ended discussion format was used to encourage carrier staff to raise any issues, perceptions, or problems they had concerning HCPCS use and maintenance. This protocol worked well, with excellent interaction and great interest evidenced by the carrier staff who participated in the discussions. At only one carrier (Indiana) did an on-site HCFA representative attend the meeting, although a representative from the Regional Office did attend in another site (Washington).

Followiong each visit a report was prepared which was returned to the carrier for review, comment, and correction, if appropriate. Four of the carriers promptly returned the report with minor modifications. The other two were called and it was determined that they had no substantive changes of additions to make.

EXHIBIT A

HCPCS CODE STANDARDIZATION PROJECT

SITE VISIT AGENDA

1. Introductions

2. Description of HCPCS Standardization Study Background and Objectives

3. Review Areas

   - History of HCPCS Implementation
   - On-site Coding Procedures
   - Editing of Precoded and CG Coded Bills
   - Problems Encountered with HCPCS
   - Anesthesia Reimbursement

Break for Lunch

4. Walkthrough of Coding/Processing Areas

5. Local Codes, Manuals, and Updating

6. Meeting With Data Processing

   - Editing Specs and Decision Tree
   - Edit Experience
   - History File Format
   - Procedure for Obtaining Tape

7. Follow-up on Carrier Perceived Problem Areas

8. Summary and Review

   - Observations
   - Next Steps

EXHIBIT B

HCPCS STANDARDIZATION PROJECT

CARRIER SITE VISIT CHECKLIST

1. History of HCPCS Implementation

   - When transition started/completed
   - Previously used coding system(s)
   - Get copy of manual and transmittals
   - Training provided
   - Procedure for handling questions -- who resolved them -- who else consulted
   - Level 3 code assignemnt -- process, criteria and plans for periodic review
   - Use of Level 3 codes

2. Precoded Claims

   - Proportion of total claims
   - Edits
   - Process for handling coding error
     - illogical code
     - invalid code
   - Potential for drawing sample for validation

3. Carrier Coding

   - Workload
     - number of claims
     - number of coders (FTE or hrs/wk)
   - Coder training and quality assurance
   - Division of labor by specialty, geographic area, major providers -- is there a supercoder for tough ones?
   - Coding techniques and aids
     - indexing aid
     - mini-list
     - automated look-up
     - other
   - Potential to evaluate impact of improved index on productivity?
   - Disposition of hard copy and/or narratives

4. Processing of HCPCS Codes

- Manual review
- Data entry decisions
  - on-line edits or batch edit?
  - which edits?
    - valid code
    - physician specialty cross check
    - diagnosis cross check
    - other
  - historical yields on edits
  - historical yields on corrections (number simply corrected vs. withdrawn vs. disputed)
- Updates of valid code edits
- History file structure

5. Liaison with Providers

- Coding questions
- Changes and updates

6. Carrier Concerns About HCPCS

- How helpful is Regional Office, BPO Central Office, AMA?
- Other resource

7. Anesthesia Reimbursement

3. SUMMARY OF OBSERVATIONS

3.1 Pre-Existing Coding System Effects

Three of the carriers were using a four digit coding system prior to implementing HCPCS (CIGNA, Maryland, and Indiana). In these cases the system changes required were major. The conversion process was facilitated when the pre-existing system was similar to CPT, when the State Medicaid agency used CPT, and when the carrier's private business used CPT. In such cases the training requirements for provider and carrier staff were greatly reduced except for special coding areas in level 2, such as durable medical equipment (DME). Also, if the pre-existing coding system differed markedly from HCPCS there generally also was a low level of electronic media claims (EMC) and precoded hard copy claims. In all cases where a four digit coding system was previously in use the carrier was running short of available unassigned codes and was quite receptive to HCPCS implementation even though the computer system changes needed were large. EMC and precoding of claims is more prevalent when all or most of the predominant payers use CPT or HCPCS since then the providers become proficient at coding, automated billing systems are less complex, and precoded superbills are common.

3.2 Extent of carrier Versus Provider Coding

Prior to implementing HCPCS provider coding was very low in the area served by CIGNA, BS of Maryland, BS of Indiana, and BS of Washington. California had a moderate level of precoded claims while Florida had a fairly high proportion. Florida, California, and Maryland had some EMC prior to HCPCS, but all carriers have since made significant gains in EMC. At the time of site visits (June-July, 1985) EMC ranged from 7 to 35 percent and the proportion of hard copy claims precoded ranged from 40 to 90 percent. As a result, the extent of carrier coding also varied widely. CIGNA, BS of Maryland, and BS of Indiana all have significant coding workload, expended substantial resources to train and monitor staff coding, and exhibit the greatest interest in coding aids.

When considering both EMC and precoding of hard copy claims, BS of Florida must code only about 5 percent of all claims received. For BS of California the figure is between 10 and 15 percent, while for Washington Physician Services the proportion is about 15 percent. The other three carriers must code from 35 to 50 percent of all claims received.

3.3 Coding Accuracy

Figures on coding accuracy by carrier staff were not readily available from the carriers with high proportions of precoded claims. However, internal quality control conducted by CIGNA, for example, indicated that miscoding was a significant source of error and constant concern for training. None of the carriers had readily available figures for the quality of provider coding, although all acknowledged that significant efforts were on going to improve or maintain provider coding capabilities. In most cases the carriers acknowledged that the EMC quality reviews could provide measures of provider coding accuracy, but one carrier indicated that the sampling was not random and focused on providers and services with established problems or suspicious patterns.

For carrier coded claims it would be possible to retrieve a sample of the original bills, or microfilmed copies, recode them, and compare the results with those in the history files. However, because of extensive logic edits included within all carriers' systems the proportion of miscoded claims will be small and usually of minor consequence. The extent to which carrier staff initial miscoding causes extra work on the system and staff to catch and correct an inconsistency is not measurable. However, the types of coding problems that are found through a recoding study could be particularly useful in designing intervention strategies (coding aids, clarifications, and training).

Review of coding by providers who submit hard copy bills is not possible at present, unless the provider submits both a narrative and a code. However, carriers do conduct an annual audit of EMC claims. The carriers report that initially there was some opposition to on-site records review, but that it has become accepted now as part of the price paid for the convenience and cash flow advantage of EMC. A protocol for use of the EMC audit authority as a basis for conducting a coding accuracy study could be developed and implemented. Alternatively, a form for abstracting record contents in narrative format for expert recoding could be prepared. Use of voluntary participation in a coding accuracy study as a means of gaining access to records was judged likely to result in non-representative results.

3.4 Status of HCPCS Updates

Four of the six carriers had implemented the 1985 HCPCS updates at the time of the site visit. The remaining two (BS of Maryland and CIGNA) planned to add all updates by the end of FY 1985. Timely implementation of updates is essential to uniformity of coding across carrier areas and to the ability to aggregate and compare data among the areas. Also, many providers routinely purchase CPT updates from the AMA as soon as issued and may initiate use of changed or added codes before these have been recognized by the carrier. Such use causes the volume of claims which must be manually priced and subjected to special consideration to increase, thereby increasing claims processing costs by the carrier. However, even though the full updates may not have been implemented by a carrier, selected portions (such as DME) or high volume individual codes may be promptly added to the processing systems.

The implementation of annual updates represents a substantial effort and cost for all carriers. Each changed code must be priced, history and prevailing charge files converted, and edits and contingencies developed. Training manuals must be modified, coding manuals revised, and all claims examiners trained regarding the changes. In one instance the carrier indicated that the computer system would be out of service for from 48 to 72 hours while the updates were run. In other cases the updates could be processed over night with minimal disruption. Although there is an informal network among the carriers for sharing information about how to handle specific problems in each update, there is unnecessary duplication of effort and at least an initial lack of uniformity in dealing with difficult problems of coverage or pricing. Carriers have asked that HCFA provide policy guidance on each new or changed code, that those codes which do not apply to Medicare by flagged, that updates be delivered with more lead time before providers receive the CPT updates, and that the updates be distributed in the form of tapes containing only the changed or added codes (not a complete revised tape of current codes).

3.5 HCPCS Maintenance

In addition to concerns about the handling of annual updates, carriers voiced concerns about the handling of level 3 codes by HCFA, needs for additional level 2 codes, the need for a central clearinghouse on infrequent but difficult coding issues, directives for dealing with non-specificities

in HCPCS coding, and the need for a variety of user aids to accompany HCPCS. A particular concern was the need to coordinate Part B benefit changes with level 2 code changes. At present the Part B benefit changes are generally announced with an effective date before the next HCPCS update. The carrier must then often assign a level 3 code, distribute information to providers on the use of this code, and make the additions to internal systems and manuals. Within a year a level 2 code is issued and everything must be turned around again for the providers and the internal systems and manuals.

Among the items which carriers requested in order to facilitate HCPCS use were:

- An approved tape containing abbreviated narratives to go with each code. The AMA abbreviated titles tape is too short for many purposes, but the full titles are too long. A limit of no more than 132 characters was suggested.
- A comprehensive listing of codes not covered under Medicare
- An index for level 2 codes
- A HCPCS maintenance manual (the HCPCS Implementation Manual was cited as very helpful and a similar manual for dealing with ongoing maintenance is needed)

It was also suggested that HCFA consider separating the CPT updates from level 2 updates. The CPT updates must be implemented promptly so as to coincide with receipt by providers of the new CPT manuals and is not under HCFA's control. Level 2 code changes could be distributed to carriers with a 60-90 day lead time and scheduled by HCFA so as not to coincide with other major changes.

4. CONCLUSIONS AND RECOMMENDATIONS

Although much remains to be done in this task area concerning HCPCS standardization, it is possible at this time to draw some specific conclusions and to pose certain general recommendations. These are summarized below.

1. Carrier coding workload is highly variable, but decreasing as EMC and precoded claims proportions increase. Carrier concerns about coding accuracy and costs focus primarily on in-house coding by claims examiners.

2. Only fragmented data are readily available through QC systems concerning the quality of coding by carrier staff or by providers.

3. Maintenance of HCPCS, particularly the annual updates, is of great interest and concern to carriers. Substantial costs are involved using current procedures and carriers believe there are opportunities for both cost savings and simplication of updates.

4. It is recommended that HCFA implement a comprehensive and on-going approach to HCPCS maintenance. This would include:

   - Preparation and distribution of a HCPCS maintenance manual

   - Coordination of level 2 code changes with Part B benefit changes

   - Distribution of level 2 updates with 90 day lead time. Because level 1 (CPT) updates are not controlled by HCFA, the maximum lead time possible should be provided.

   - HCPCS updates should be distributed in the form of tapes containing all changes or additions. Complete revised and updated HCPCS should be available, but not routinely distributed.

   - Each update should be accompanied by an explanation for each change or addition, including policy guidance on pricing, whether or not an assistant should be paid, if applicable, or if a laboratory test, whether anatomic or clinical, etc.

   - An updated listing of codes which do not apply to Medicare should be made available to carriers

   - A clearinghouse on coding problems and decisions should be formally organized. The clearinghouse would deal with:

     - infrequently occuring problems which cause a large expenditure of time when they occur

- handling of non-specificities in HCPCS (situations where combinations of codes or single codes can be used to describe the same procedure, problems of "unbundling" of services, and descriptive narratives which are unclear)

- contingencies and edits for various codes

- requests for clarifications or modifications which should be brought to AMA attention for level 1 codes, or to HCFA's attention for level 2.

o The clearinghouse could also distribute coding aids or information on performance of commercially available coding aids.

o When a level 2 code is deleted, that code number should be retired for at least 2 years.

APPENDIX A

SITE VISIT REPORTS

FOR

Medicare, Part B Operations

- CIGNA
- Blue Shield of Maryland
- Blue Shield of Florida
- Blue Shield of Indiana
- Washington Physicians Service
- Blue Shield of California

SITE VISIT REPORT

CIGNA, MEDICARE PART B

Wallingford, Connecticut

June 19, 1985

The site visit team consisted of Harry Savitt, HCFA/BDMS, Howard West, Mandex, and Ben Duggar, SAIC/JRB. Pat Ingeno, Manager of Programs and Controls, Medicare, for CIGNA made all arrangements for interviewing CIGNA staff as well as representatives of the EDP contractor, FIDATA. The interviews and a tour of the facility required approximately three hours on-site. All of those interviewed were well prepared for our visit and Ms. Ingeno kept the discussions and interviewees to a tight but comfortable schedule. The following paragraphs outline the information gathered and highlight HCPCS issues which were identified.

1. History of HCPCS Implementation in Connecticut

Prior to January 1984 CIGNA utilized the 1964 CRVS for coding of services under Part B. The conversion to HCPCS occurred on January 3, 1984 following an extensive planning, preparatory, and training period. The limitations on the number of 1964 CRVS codes (about 3,000) and their relative obsolesence had already produced problems at CIGNA, so they were receptive to the conversion. For their private business CIGNA was using a more recent version of CRVS, but many providers were already using CPT-4 for other purposes.

In preparing for conversion CIGNA used the 1983 HCFA conversion manual and the HCPCS tape, both based on the 8th edition of CPT-4. These were used to develop a CRVS to HCPCS conversion tape. Because CIGNA had created a number of codes for currently used procedures not in the 1964 CRVS and because of the relative lack of detail in CRVS, there were some problems in mapping all previously used codes to HCPCS. The updated HCFA tape based on the 9th edition of CPT-4 arrived two weeks before the

implementation date of January 3, 1984. Because the training had already been given and manuals printed, etc. CIGNA stuck with the 8th edition which they are continuing to use today (new codes have been added as providers submit bills containing them). CIGNA plans to update to CPT-1985 later this summer, and will then update annually thereafter.

In preparing for the conversion CIGNA offered workshops to the various provider specialty groups. Seven workshops were run, with about 150 providers attending. In addition, a number of providers received extensive consultation by telephone, or traveled to Wallingford to obtain help. Appendix A to this site visit report is a copy of a bulletin distributed to all providers introducing the changeover and listing the 44 Level III codes assigned by CIGNA to replace CRVS codes not in CPT-4 or Level II at that time.

2. System and Code Changes

Because the '64 CRVS were 4 digit codes, the conversion to HCPCS with five digits plus modifiers required a redesign of the files. To simplify the conversion CIGNA only provided space to carry one modifier per code rather than two. Local options for modifiers are then assigned to represent the occassional circumstances where 2 modifiers may be needed for the same code. This worked well until the most recent update when CIGNA discovered that HCFA had used one of the "local option" modifiers for a Level II assigned modifier. This has caused problems.

Because of the major workload caused by Medicare changes over the past 18 months, CIGNA has not formally incorporated the HCPCS updates. However, when a provider submits a code not found in the system, the claim is suspended and referred to the Program Reimbursement Department. If the technician finds that the code is from CPT-1985, for example, the procedure is priced and is added to the file. Adding the code requires that all edits and contingencies relating to that code also be developed and added at the same time. When CIGNA does the large update in the fall of 1985, they will have to convert old codes, and modify edits --- it was estimated that the computer system would be unavailable for routine processing for from 48-72 hours to accommodate the update process (over a weekend plus to one day).

The process for converting the old '64 CRVS to HCPCS codes in the customary and prevailing file was the largest problem encountered. The first step involved constructing a conversion table in which one CRVS code often was related to 2-3 HCPCS codes or vice versa. The few left over CRVS codes were then assigned Level III HCPCS codes. to price out the HCPCS code, CIGNA used the CRVS code price when the conversion was a simple 1 to 1. When a CRVS went to several HCPCS codes the old price went to each of the new codes. However, when several CRVS codes went to a single HCPCS code CIGNA had to study each and reach a decision for using one of the original CRVS code prices, based on use and impact, to apply to the new HCPCS code. When the history file was run to convert CRVS codes to HCPCS, they used the first listed HCPCS code when several alternatives applied. There was no problem in the history when two CRVS codes were converted to the same HCPCS code.

It was estimated that CIGNA currently assigns 4-5 Level III codes each year. The code update in the fall will result in deletion of some of the local codes because these will be included in Level I or II. Because AMA gives a "suggested" code for use when an obsolete code is deleted it is very easy to handle their updates. Also, AMA does not reassign a phased out code number for several years. The fact that HCFA recently changed the definition used for a Level II code (phased out the old definition and reassigned the number to a new description simultaneously) caused difficulties for CIGNA and should be avoided in the future if possible.

The update to CPT-1985 involves much more than the system changes and new edit -- the training and coding manuals will also have to be revised and reprinted (there are about 100 copies in the Part B Processing Office). It was estimated that 2-3 person months will be devoted just to identifying the changes needed in the manual. This with the production costs makes it an expensive undertaking.

3. Provider Coding

Providers handled the conversion to HCPCS well. CIGNA distributed the Level II & III codes, but the providers had to purchase CPT-4 from the AMA. The providers tend to get and use new editions to CPT as soon as they hit the street and therefore it is important that HCFA try to

identify new revisions and get these out to Carriers at least a month before AMA distributes CPT-1986.

The level of EMC claims submission in Connecticut was relatively low, but is now climbing and should reach about 14 percent for the year. The conversion map was shared with all EMC providers to assist with their conversion. Right now the EMC group consists of 12 billing services (one of which is a large clinical laboratory which also prepares bills for smaller labs) and 12 large volume providers.

All providers have been given Pat Orlando's number for coding questions. If the question is how to code a new complex procedure, Pat instructs them to send it in on hard copy and with a narrative description and a copy of the "operations report". The claim is then sent to Medical Review for coverage determination and code assignment.

There is no requirement that providers precode hard copy bills, but a significant proportion do so. Some providers submit precoded "superbills" attached to the 1500, some code on the 1500 (claims examiners processing a superbill attached to a 1500 do review both sheets).

Some physicians have taken issue with the specifics in the CRVS to HCPCS conversion -- this because the providers are looking carefully at their profile because of the current "participating" program. They often confuse what happened in the conversion with the participation freeze. It was also noted that some physicians have used carrier listings of codes with prices as a way to get around the freeze -- just use a new similar code not previously billed.

CIGNA does not code diagnosis nor enter it into the history file. On EMC submissions it is there and is coded in ICD-9-CM.

4. Carrier Coding

All Claims Examiners are trained to code in HCPCS as part of their basic training course. This is a 6 week course working with the books how to code, on what is/is not covered, etc. and is then followed by 2 weeks working on the CRTs. Training of Claims Examiners is a continuing activity at CIGNA Part B since there are about 60-80 claims examiners and significant turnover.

When the hard copy claims come in they are sorted, the control number assigned, and the claim scanned for any obvious problems. The carrier will find and add a missing provider number, and only return the claim when there is a major problem that can't be resolved otherwise. The claims are then assigned in batches to examiners for development. Only certain unusual service claims are given to specific examiners who specialize in that service (DME and laboratory). The examiner checks on the procedure code if already precoded, or looks it up from the narrative when not already memorized. The examiner then enters the code on the CRT which has on-line edits to prevent use of a non-existent code, or if there is a logical inconsistency (sex specific code or place of service, for example, disagrees with patient data or type of service). When a narrative description is encountered which the examiner can't code, it is referred to the RN in the coverage group, and if not resolved there it is referred to the medical consultant. If it still can't be coded, Linda is asked to make the code assignment.

For EMC, the examiners call up the claim on the screen, review it, correct any deficiencies, and then release it. If an unknown procedure code is encountered, the claim is suspended and referred to the reimbursement department.

Coding is monitored through two procedures, the daily LST report which counts the number of times different edits were called into play to suspend claims, and the QA system. The LST report can be used to count the number of times a procedure code was encountered not also on file -- would apply only to EMC since examiners cannot enter a code not on file. CIGNA usually only keeps the LST reports for a few months, then destroys them. However, they will keep the month of June 1985 for us as a benchmark.

The QA group does a sample of claims every week and describes reasons for errors in great detail. Coding errors are reported to be the single largest type of error. For an arbitrarily selected week in April there were 78,000 claims processed and 158 of these were sampled for QA. Sixteen of the 158 (about 10 percent) were found to have coding errors, although the significance of most was minimal. There is a quality assurance task force that works with these data and tries to get at reasons for the errors and to introduce interventions (for FY 1984 CIGNA ranked very good among all carriers on underpay/overpay errors).

5. Anesthesia Coding

Prior to converting to HCPCS CIGNA used the 1967 ASA RVS to assign base units for each surgical procedure code. When anesthesia claims come in the time units are entered in the "Number of Services" field. The surgical procedure code is used to determine the number of base units which is then added to the time units and then used to compute the price based on the customary and prevailing profile. The examiner may call up the history file to see what the surgeon's code was when the anesthesiologist's description is vague. Usually the anesthesiology claim comes in first though, so the examiner may have to hold the anesthesiology claim until the surgeon's is received. Anesthesia services is recognized as a big problem because of the large reductions from billed charges which result from the prevailing limit. Almost none of the anesthesiologists have reimbursement affected by their "customary" anymore.

The history file does have the time units and the procedure performed -- however, we would need to have the RVU's in order to compare costs to Medicare of using ASA-1985 versus the preexisting system.

6. CIGNA Concerns About HCPCS

- When HCFA deletes the assignment of a Level II code, they should retire that code designation for a few years. If the number is reassigned immediately (as was done with a DME code recently) the Carrier files and provider coding practices must be instantly converted or the two services will be forever confounded and inappropriate payment may result.

- The originally promulgated local code range and two digit modifiers must be protected from central office assignment. CIGNA found one of their local option modifier codes is now being used by HCFA in Level II for a different purpose.

- The lengths of the longest narrative descriptions on the HCPCS tape provided by HCFA are too long to fit in the CIGNA file (132 characters) and so have been truncated. Is there an abbreviated narratives tape? What have other carriers done? the AMA abbreviated titles tape (28 characters??) is too short for use in the file which translates codes to narratives on the CRT.

- Why are there already RVUs in the printed manual and the HCFA HCPCS tape? There also were already some Level III codes on the tape? Did HCFA want all carriers to use these RVUs or Level III codes? (CIGNA did not.)

7. Other Observations

- CIGNA does not use the AMA "place of service" codes on the 1500 -- use the old Medicare codes. Although some precoded bills may use the AMA codes, many would be picked up and corrected based on edits -- a provider who regularly used the AMA codes would therefore be identified and contacted. Consequently, CIGNA feels the place of service codes they have on file are probably mostly the Medicare ones.

- CIGNA would like to have access to a central clearinghouse on coding problems and decisions. Major problems don't occur often, but they cause a large expenditure of time when they do come up.

- The fractures and dislocations procedures are a coding problem -- the HCPCS descriptions are so similar and the narratives by the provider so brief that coding errors are frequent.

- Providers tend to not read the definitions at the front of the CPT manual for "brief" and "intermediate" and therefore make mistakes.

- CIGNA does audit a sample of each EMC providers claims every year. Check the medical record (or equivalent) against the claim, check for signatures on file, check charges.

- CIGNA recently submitted the 1984 BMAD tapes -- they were 100 percent rather than a sample.

8. Conclusions and Agreements

a. CIGNA appears to meet all of the requirements for conduct of the HCPCS standardization study. They also recognize the problems with HCPCS and can provide documentation for guaging at least some of the impacts anticipated from HCPCS improvements.

b. CIGNA will save a month of LST reports (June for example).

c. HCFA will determine if there is a more appropriate HCPCS abbreviated title tape and, if available, provide it to CIGNA.

d. Most of the HCPCS study can be done using BMAD tapes in central office with limited activities conducted in Connecticut.

e. HCFA must implement a system for maintaining HCPCS such that certain of the problems noted by CIGNA do not occur. Also, because the costs of updating HCPCS files by the carrier are large, a longer term objective should be to try to reach the point where updates can occur less frequently. Alternatively, lower cost ways of handling updates should be developed.

SITE VISIT REPORT

Blue Cross and Blue Shield of Maryland

Medicare, Part B

June 24, 1985

The site visit team first met with the BC/BS staff to review HCPCS implementation, status, and perceived problems. This was followed by a walk through of the processing area and then a final review of remaining questions. Participants were:

Lee Bernhardt, Vice President, Government Programs
Bonnie Bullock, Assistant to the Director, Government Programs
Charlotte Petersen, Coordinator for Quality Assurance & Provider Relations
Regina Smith, Administratative Services (Training, Systems, BMAD, etc.)
Darlene Bill, Physician's Profile, Part B
Harry Savitt, HCFA
Howard West, Mandex, Inc.
Ben Duggar, SAIC/JRB

Highlights of the information collected appear in the paragraphs which follow.

1. History of HCPCS Implementation in Maryland

Prior to implementing HCPCS BC/BS used BSM, a four digit coding system containing about 6,000 codes (versus 10,000 in HCPCS). The conversion occurred February 24, 1984 after an intensive period of planning, training, system changes and file conversions. The date for conversion was originally set for January 1, 1984 and providers were notified in August 1983. A series of five seminars for providers were set up during September-December and were well attended (see Exhibit A, announcement letter).

Because of the magnitude of the system changes required, the implementation date slipped to February 24, 1984. January 1984 was the training month for BS Part B claims examiners (there are about 60). At the time of the conversion EMC was a nominal volume (less than 20 percent), with most paper bills being the HCFA 1500. Other than the underestimate of the amount of work required and the slippage in the date, the conversion went smoothly.

2. System and Code Changes

Because BSM used prior to HCPCS consisted of four digits, the changes needed to accommodate five digit HCPCS codes and 2 two digit modifiers were

major. Also, the change from about 6,000 BSM codes to 10,000 HCPCS codes involved substantial efforts to devise a conversion table. Charlie Smith, Ann Evans, and Alan Bradt of HCFA helped in planning the conversion. Because the 10,000 HCPCS codes could not be simply collapsed to the BSM codes, from 300 to 500 level 3 codes had to be initially developed. The 8th revision, distributed by HCFA in the late fall of 1983 was implemented and remains in place at this time. A major file update, to include the 9th, 10th, and 11th revisions will be implemented before the end of the current fiscal year (the many other priority changes to Part B have necessitated defering updates until now, although the 400 or so DME codes were added to permit compliance with the "least cost" directive). Because many providers are already using new codes in the CPT revisions, the need to implement them into the system has become pressing. When an EMC bill has a code currently unrecognized by the system it is suspended and a manual check performed to determine if the code is in one of the updates---if it is, it must then be manually priced.

Each HCPCS code in the system has a corresponding set of edits. Also, the system has been set up to accept certain "short hand" or mnemonic codes from the BS coders (BO for brief office visit, for example) and translate these to the HCPCS code (see Exhibit B). The old BSM codes are also stored in the system with the conversions since some providers occasionally use one of the old codes.

3. Provider Coding

At present EMC is up to about 28 percent of all claims. Most of the EMC group are high volume providers and knowledgeable about coding. They also received special attention during the conversion to HCPCS and when they first apply for EMC authorization. All EMC bills use the Medicare place of service codes, not the AMA codes on the back of the 1500.

Assigned hardcopy bills are 40-50 percent precoded and assignment rate is now averaging 70+ percent. Very few non-assigned hardcopy claims are precoded. Most bills are on the 1500 since Blue Shield has discouraged the use of superbills.

Providers with coding questions call the BS professional relations representative or claims support person. If the recipient of the call cannot answer the question, it is referred to either medical policy (coverage questions) or to Charlotte Petersen (for clarification of coding instructions). Records of incorrect coding, both on EMC and hard copy, are kept and providers contacted

who exhibit consistent problem patterns. About 10-15 providers are contacted each month. Although this works well for most providers, some are very persistent in the use of aberrant codes.

4. Carrier Coding

When hard copy claims are received they are date stamped, scanned for completeness, and sorted as to DME, DDE (Direct Data Entry or "streaker" one liner claims), MSP, or "all other". The DME claims go to a small group of processors who have had special training for these. The DDE go to data entry clerks, while MSP go to special processing clerks. The bulk of the claims, however, go to the coders. The coders also do medical necessity reviews while coding the procedures. After coding, the hard copy is microfilmed then sent to data entry. The on-line edits during data entry are very complex and provide a good probability that any coding errors or inconsistencies will be picked up and corrected.

The coders have lists of common codes and lists of frequently occurring problem areas. These "cheat sheets" are made up during training classes by the students as they cover the codes. The coders also learn the mnemonic short hand codes, and can call up old BSM codes on the screen for reference.

EMC bills are batched and released to claims reviewers. If there is a problem such as an incorrect or missing item the reviewer attempts to make the correction. If she can't resolve the problem the claim is passed to an "individual consideration" specialist. It may go to an RN in Medical Policy next if still unresolved, and finally to the Medical Director. In the case of some coverage issues the Regional Office may be contacted. However, calls are not made to the AMA concerning CPT coding problems. The internal QA group reviews a sample of each coder and reviewer's work each month. Also, certain of the batch applied computer edits relate to provider or BS coder errors (List 1 and List 2). Blue Shield will save the June 1985 listings as baseline information for use in estimating benefits of an improved HCPCS index and other coding aids. BS also audits a sample of Medicare EMC bills at least once a year by comparing the bill with the providers medical records. Provider hard copy bills are only audited when QA detects a problem.

5. Anesthesia Coding

Blue Shield has anesthesiologists report the surgical procedure or

surgeon's code for both its private business and for Medicare Part B. Anesthesia relative value units for each surgical code are programmed into the system based on the 1973 Blue Shield guide for RVUs (a tape could be produced containing the RVUs for each procedure code). Modifiers concerning the patient severity or special circumstances are not recognized. Anesthesia bills are received, then the RVUs for the procedure added to the time units (1 unit for each 15 minutes for an anesthesiologist, for each 30 minutes when a CRNA administers the anesthesia). Most of the anesthesia groups in Maryland employ the CRNSs except for Johns Hopkins where they are hospital employees. The total RVUs are then converted to dollars based on the providers UC profile. There are 3 localities (Baltimore area, Eastern Shore, and Southern Maryland, and the Western part of the State) for the "prevailing" limits. Most anesthesiologists now have customary charges exceeding the prevailing limits, but there still are a few that don't. There also is only one general practitioner in the state being reimbursed for anesthesia (his anesthesia claims must be priced out manually).

The anesthesia bill usually is received and paid before the surgeon's bill arrives. On the few occassions when BS has gone back and linked dissimilar coded bills for the surgical episode, the anesthesia bill code was the one that was wrong.

BS of Maryland conducted a study about 1980 comparing the ASA codes with the present procedure of assigning RVUs based on the surgeon's code. We should contact Denise Noll in the Medical Policy Division to learn more about this study.

6. Other Concerns and Observations

When HCFA sends out HCPCS updates on hardcopy and on tape there should be some accompanying documentation. In particular, since all carriers now use HCPCS, and since coverage decisions should be uniform it would be most efficient if a central work group developed a suggested list of contingencies and edits to go with each code. This would also speed the implementation of the revisions once received by the carrier.

DRAFT

SITE VISIT REPORT
BLUE CROSS AND BLUE SHIELD OF FLORIDA
Medicare, Part B

Jacksonville, Florida

July 9, 1985

The site visit team consisting of Harry Savitt, BDMS, HCFA, Howard West, Mandex, and Ben Duggar, SAIC met with the following Blue Cross and Blue Shield (BCBS) staff:

Louise Beckom, Manager, Part B
Dick Dever, MD, Medical Director
Juanita Coleman, Supervisor, Med. Division
Arlene Johnston, Mgr., Med. Division
Jonnye Tomery, Operations Analyst, Tech. Serv.

The site visit included extensive discussions regarding HCPCS implementation, HCPCS maintenance, BCBS of Florida concerns, and anesthesia services reimbursement. A walk through of the processing area and observation of claims examiners activities was also included in the visit. Highlights of the discussions and observations appear in the following paragraphs.

1. History of HCPCS Implementation in Florida

In July 1982 the Florida Medical Association (FMA) converted to a system based on CPT-4. BCBS was previously using the 1975 FMA Relative Value Studies (FMARVS) and in July 1982 they also converted to the CPT-4 based list to conform to FMA, this being Phase I. In July 1984 HCPCS Levels 2 and 3 were implemented and Phase 2 was completed (HCPCS was fully implemented). Both phases of the conversion were fairly uncomplicated since FMARVS was similar to CPT-4, and when Level 2 was implemented many of the HCPCS codes were those previously considered locally assigned by BCBS of Florida (particularly for DME). BCBS did a recomputation of RVUs based on relative charge data and obtained some RVs from the Atlanta Regional Office.

There were more codes in FMARVS than in HCPCS and BCBS was about to run out of unassigned numbers, so the conversion was well timed for them. Initially a number of the codes were carried as "relativity not established" or "by report," but these were soon worked out. If the "relativity not established" procedure was in FMARVS, the payment was often based on statewide rather than economic area data.

In 1982 BCBS published a physicians manual which included all Level 1, (FMA negotiated with AMA to use CPT-4 as part of the FMA system)., Level 2, and Level 3 codes. The News Notes sent to special providers also covered coding. BCBS also made up lists of the most frequently billed codes by specialty which they pass out to the specialty groups.

Because of the way the transition was handled and because of the concurrent FMA conversion to CPT-4, there were no major systems problems, and provider coding was already being addressed by FMA. The first conversion table submitted by BCBS to HCFA was rejected since some of the narratives were not identical to those in HCPCS (BCBS used some abbreviations since they wanted to limit narratives to 192 characters).

2. Provider Coding

In addition to the manual and lists distributed by BCBS any provider can purchase a manual from FMA, or can purchase CPT-4 from AMA. The use of precoding by providers is strongly encouraged and, other than EMC, about 90% of claims are now precoded. EMC is approaching 35% of all claims. The use of precoded super bills is encouraged, but the codes must match HCPCS --- most providers will submit their draft billing forms for review prior to printing/purchasing large supplies.

Providers with coding problems can contact BCBS, there are reps in the local BS offices and Juanita's phone number is also listed for these problems. If the provider makes a suggestion or complains about the coding system he is usually referred to his own specialty representative on the editorial committee. Coding questions are usually handled by the BCBS staff -- the tough ones are referred to Arlene who may in turn directly contact the AMA for clarification of a CPT description, or advise the physician to contact the AMA. A physician using an incorrect or phased out code will receive a message on the EOB which gives the correct code (most providers will correct their coding practice in order to assure prompt payment.)

3. Carrier Coding

BCBS has about 300 claims examiners for Part B and works a two shift operation to handle the approximately 28 million claims each year. Training of new examiners is a continuing activity and includes handling of all types of claims. Because DME claims are sorted out and processed by a special group, there is special training for DME examiners.

For EMC the computer screens all codes, applies the edits, and suspends those requiring examiner review. For hard copy claims the sequence is: 1) logged in and control number assigned, 2) microfilmed, 3) batches distributed to examiners as needed (except DME claims which go to the DME group). Examiners enter the code from precoded claims and then address the "policy" issues which apply to certain codes. Because of the low proportion for uncoded claims, coding is not a major effort by the carrier. However, BCBS does provide examiners with a number of coding aids. First, the computer contains extensive edits and advises the examiner if the code is illogical, and the terminal will not accept an invalid code. Second, a coding manual is provided to each examiner. There are also special purpose manuals. For example, a new manual on prosthetics and orthotics has just been released which defines what is or is not included in each code (this manual is also available to providers). Third, there is an automated look-up of the narrative to go with each code. Fourth, when a code is discontinued, it is left in the computer for two years and provides a notation to the examiner of what the new code should be. Many of the policy issues on coding are on-line and lookup is automated. However, there is no index if the examiner needs to code an item in Level 2.

Because most coding errors are handled by on-line edits which prevent entering an invalid code, and since most claims are precoded, there is no internal management report item dealing specifically with examiner coding errors. However, examiner productivity is monitored.

BCBS of Florida currently has between 500 and 800 locally assigned codes. The carrier prefers to assign a local code rather than to use an NOC code since with a local code all edits can be added and the reimbursement determined once and entered into the computer file. Florida providers tend to be early in trying out new procedures, so the carrier gets a lot of these and using NOC codes would be cumbersome. The carrier must coordinate local code assignment with Medicaid, Travelers, and the National BSA. Therefore, about 30 day notification time is needed before implementing a newly assigned code. BCBS did receive the list of

local codes for verification from the Regional Office. The list was mixed up with the Florida list identified as coming from Alabama (carrier number was correct, though).

Claims examiners enter the Medicare "place of service" code rather than the AMA codes printed on the back of the bill.

4. HCPCS Updates

The 1985 update was operational by July 1, 1985, but because the tape was not received until late January and because of all the other pressures and activities it was close timing. For future updates BCBS of Florida needs at least 90 days --- 30 days to review and code the changes and enter them into the system, and 60 days to make the policy decisions and develop the edits to go with each.

Although it appears that there is much duplication in the efforts made by each Carrier to implement updates, there is no formal provision to avoid the duplication. There is a national Blue Shield committee for jointly developing and sharing technology assessment information, and this is very helpful. A similar mechanism would be useful for addressing issues of edits, audits, and reimbursement for HCPCS updates. An informal network does exist among the carriers (e.g. many carriers call Florida to find out how they plan to handle particular issues, while BCBS of Florida may also call several other carriers to interchange ideas). Carriers also call the Regional Office when there are policy issues. It would be very helpful if HCFA would include general policy guidance for each new of changed code in the annual updates.

Other comments and suggestions regarding HCPCS were:

- The HCPCS Implementation Manual was helpful and there now is a need for a Maintenance Manual.
- New codes and changes in existing codes from HCFA should come with explanations of the reasons for the changes.
- The national meeting on the J (injections) codes was a great idea. There was much helpful interchange and this model should be used for other problem areas.

- Previous changes have been handled in a confusing manner -- two examples illustrate the problems which are created:
    1. When the bilateral codes were deleted on one update, then put them back in the alpha codes on the next, the Carriers who promptly implemented were caught with egg on their face. They had just turned the providers around! If HCFA had notified them six months earlier they could have avoided most of the confusion.
    2. One of the updates was confusing in that a printout of the changes came first --- then a month later the tape came, but the tape had more changes than were on the printout!
- If new codes appear in updates which do not apply to Medicare, there should be an attached disclaimer which so states.

5. Anesthesia Services Reimbursement

The ASA members in Florida have been actively urging BCBS to use the ASA codes. However, BCBS sees many potential problems. Because there are only 237 anesthesia codes versus the 5000 or so codes for surgical procedures there would be a lot of "bundling" of procedures and loss of information as to what was going on. If the ASA codes are adopted, what happens with the modifiers? If the modifiers are used it could both be inflationary and require major systems changes to accommodate two modifiers plus the time modifier. Other concerns deal with how to handle multiple procedures, how to discriminate between a covered and a non-covered procedure, and the problem of tracking unbundling of "included" procedures (e.g., one anesthesiologist inserts the anesthesia tube and bills for it, another administers the anesthesia and bills for that).

If HCFA decides to go to CPT-4 codes for anesthesia, they should also issue very specific guidelines since there are so many flexibilities. The carriers already have problems with CRNA reimbursement with a rash of modifiers and with differences between payers as to reimbursement practices (e.g. BS private business uses 10 minute time units vs. Medicare's 15 minutes). BS private business doesn't allow much separate billing and doesn't accept the patient status, unusual services, or qualifying circumstances modifiers. If there is a changeover to the ASA codes HCFA

should also distribute the conversion table (each carrier would still have to convert their own Level 3 codes.)

In Florida the prevailing conversion factor for each of the four economic areas in the state is now the same. Even with this and the downturn in surgery the anesthesiologists in Florida seem to be doing well. Many have expanded their product offering to do more work in the CCU rendering personal care, some fired their CRNs and brought in other anesthesiologists to increase their gross billings, and then there is the unbundling phenomena.

6. Other Observations

Much of the electronic media claims volume is transmitted by phone line over night. The large volume providers have a smart terminal which stores the claims on a cassette all day. At midnight the Blue Shield computer poles the terminals and reads the cassettes. The large billing services typically submit tapes. BS has the capability to interface with most other computers or systems if they become common in Florida.

For auditing of EMC there is a stratified random selection of 25 claims per year for each provider. Accuracy of procedure coding is part of the audit. Initially the providers were very resistant to on-site audits, but they have come to accept it.

Florida has run frequency of use counts on CPT/HCPCS codes --- but they haven't run lists of codes not used.

BCBS of Florida has submitted its BMAD tape. They are a sample carrier and not one of the 100% submitters.

SITE VISIT REPORT

Blue Cross and Blue Shield of Indiana

Mecicare Part B

July 16, 1985

The site visit team consisting of Harry Savitt (BDMS, HCFA), Howard West (Mandex) and Ben Duggar (SAIC/JRB) met with Julie Kellam (Manager, Claims Processing, Medicare Part B), Robert Clark (Medicare Coordinator), Gordon Hicks, Unit Manager, Herb Bazemore, Unit Manager, Chris Haaff (Provider Relations) and Marvin Laphew (HCFA on-site representative) at the Blue Shield building in Indianapolis. The purposes of the visit were to review HCPCS implementation experience, document problems and suggestions, assess suitability of using BS of Indiana data for the HCPCS coding standardization study, and to document anesthesia services reimbursement practices. Highlights of the informaiton collected appear in the paragraphs which follow.

1. History of HCPCS Implementation in Indiana

Prior to HCPCS BS of Indiana used a four digit coding system which represented a mix between NABSP and CPT codes. At that time there were no EMC claims, few claims were precoded (10-15%) and few providers maintained code books for Medicare. Preparation for the conversion began on July 1, 1982 and the change was formally implemented on January 1, 1983. The preparation required that a dedicated group of five staff members (the "HCPCS 5") spend nearly 6 months working out the details.

BS of Indiana uses EDS as a subcontractor for the computer system. Although Florida also uses EDS and converted prior to the Indiana conversion, Florida was already a CPT code user and the changeover was relatively easy. Thus, Indiana represented the first substantive conversion by EDS to HCPCS. EDS prepared the crosswalk to facilitate conversion

and made major systems modications to carry the five digit alpha numeric codes. Because of difficulties in accommodating two 2 digit modifiers, BS of Indiana developed a series of local code modifiers to represent two codes when needed. This practice was continued until June 3 of 1985 when a new system was implemented which now accepts two modifiers.

Medicaid in Indiana requires CPT, but what system BS uses for its private business was not known to those interviewed.

Initially, about 350 local codes were needed, but this was whittled down at HCFA's insistence to about 44 local codes at time of implementation. New codes are assigned as needed, but HCPCS updates often reduce the number. It is now up to between 100 and 150 Level 3 codes.

2. Provider Preparation and Coding

Prior to implementing HCPCS there was minimal provider coding and the assignment rate was only about 30 percent. HCPCS definitely helped, with the assignment rate increasing to about 50 percent (and now even higher) and the extent of precoding building up to about 60 percent of claims. This has also helped claims examiner productivity.

To prepare for the conversion all providers who submitted more than about 100 claims in 1982 were sent printout listings of Level 2 & 3 codes and were instructed how to order CPT-4. BS also made up lists of codes by specialty and distributed these, as appropriate. Minimal training was given to providers, but they are provided with a phone number to call regarding coding questions. Chris Haaff estimates that he receives 10-12 requests per day for information on coding (he will keep records for a few weeks to provide illustrations and a rough estimate of workload).

EMC is growing in Indiana and is now up to about 16 percent. Quality of provider coding for EMC is not considered to be a problem. Superbills are a minor problem since the providers do not promptly revise them when the codes change --- may take a year or two to use up the old supply before reprinting.

3. Carrier Coding

Intensive training for claims examiners is an ongoing effort at BS of Indiana. There are about 80 examiners handling 360,000 claims per month. Classes consist of from 10-15 examiners and 90-95 percent successfully complete the training course. Computer based instruction is extensively used and coding is a major component of the training.

When claims are received only the DME claims are assigned to a separate group of examiners. Batches of other claims are assigned to examiners as each finishes a previous batch and goes on to the next. The DME examiners were still doing manual processing at time of the visit and consisted of a group of about ten individuals. Assigned claims are separated from unassigned claims in the batches, but there is no attempt to sort them by specialty or by type service (other than DME).

As the examiner keys in the HCPCS code the computer edits for whether it is a valid code and whether it is logically consistent with other items on the bill. If, for example, the code and charge are inconsistent with the customary and prevailing stored in the computer, the computer instructs the operator to recheck the procedure code. In many cases the computer also calls up a contingency check (e.g., certain laboratory tests are only covered when the diagnosis on the bill is one which justifies it). The computer has an automated look up of narratives to go with codes.

Coding errors by examiners is not considered to be a problem. EMC codes are subjected to batch edit checks and all potential problems suspended until reviewed by an examiner. When coding questions arise, the staff attempts to resolve them internally. If they can't find the answer, they may contact the regional office, but have not in the past contacted the AMA of central office about coding question. If the staff cannot resolve a coding question, the bill is suspended and the computer generates a letter which is sent to the provider to obtain additional information.

All claims are assigned a control number and hardcopy claims are microfilmed with the control number. Thus, validating carrier coding of a sample would be possible.

BS of Indiana examiners operate under a incentive system such that speed and accuracy are important. Processors who exceed the standard receive 6¢ per document over the standard, but there is a penalty for each excess error. The maximum bonus so far has been $105 for a week of exceptionally high production, and accuracy.

4. HCPCS Updates

BS of Indiana is current on all HCPCS updates. In 1984 the update was handled by a task force and was complicated by the concurrent efforts on a new system. However, the update was implemented at night and over weekends and did not require taking the computer out of service. The 1985 update was implemented in mid-March of 1985. The HCPCS tape was less useful for CPT changes than was CPT-1985 --- it has a list of what was changed. Each change involved a repricing, development of edits and audits, and the entry of the change to the current file plus conversion of the history files to be consistent. Some types of changes are particularly bothersome --- for example, the addition of side rails to the DME hospital bed code (previously there was a DME code for the beds and a code for the rails) requires a more complex process to go back into the history and combine two previous codes into one.

HCPCS updates are also a problem for providers. Although most obtained CPT-1985 as soon as available, those using superbills often do not reprint them with updated codes until a year of more later. If HCFA reassigns a phased out code without waiting several years, the bills come in with valid codes indicated, but they may be for the incorrect service! Thus, incorrect payment may result. The BS of Indiana computer keeps the old codes and conversion available to the examiners as long as is needed, but manual cross-checking each occurrence to determine if it was coded correctly is inefficient.

BS of Indiana needs to have updates at least 90 days before implementation and would prefer 120 days. The update would be facilitated if HCFA provided a list of the changes and for each the following:

- Reason for deletion of an old code
- Whether or not an "assistant" should be paid, if applicable
- If a lab test, whether anatomic or clinical
- Other information helpful in pricing it.

It was also suggested that HCFA might consider splitting the updates --- give the CPT changes in November for a March 1 implementation, Level 2 changes in May or June for implementing within 120 days.

5. Other HCPCS Comments and Questions

- When a code is deleted from HCPCS, the pricing in the history is lost forever. If the code is then brought back a year or two later, please give the pricing as well.

- Why duplicate codes in the ESRD section?

- Old phased out numbers reassigned (e.g. E0160) produce big problems for carriers.

- Any code subject to the Economic Index will have to stay in the Index even if deleted from HCPCS. Therefore, these code numbers cannot be reassigned until the E.I. is also revised --- may be many years!

- There are too many codes that are seldom used --- if the carrier converts the minor variations back to the main code, the provider complains even though the reimbursement is the same. However, if the minor variations are deleted from HCPCS, nobody complains unless the minor variation was reimbursed differently.

- There are always new lab services needing codes. The carrier must decide if clinical or anatomical and help would be appreciated.

- BS of Indiana likes HCPCS, It has greatly contributed to precoding by providers, to productivity of examiners, and to quickly being able to come up with "customary" charges when a physician moves into the area. It has been possible to include lots of "look-up" formerly in the manual into the computer (this is more a result of the new computer system than HCPCS, but there is a relationship).

- BS of Indiana has submitted the BMAD sample and has already reviewed and updated the list of Level 3 codes sent from the Regional Office.

6. Anesthesia Coding and Reimbursement

Prior to conversion to HCPCS the narrative descriptions of the surgical procedures were used. Most anesthesiologists give both the code and narrative today. Time and physical status (P1-8) modifiers are also used for reimbursing under Part B.

For purposes of the anesthesiology reimbursement study there is a problem in that the "time" units and "physical status" units are added together and appear in the history file or BMAD tape as a single figure. However, complete and dissagregated data can be manually retrieved from the microfilmed records of bills. Most anesthesiologists submit hard copy claims.

For anesthesiologists only in Indianapolis there is a "bonus" time unit awarded for each additional hour after two full hours (e.g. the time changes from one unit every 15 minutes to one unit every 12 minutes after 2 hours). The RVUs for each procedure were adapted from the 1971 ASA guide. However, Blue Shield uses the 1981 guide for its private business (this according to discussion with local anesthesiologists).

Site Visit Report

WASHINGTON PHYSICIAN SERVICE

July 23, 1985

The meeting was attended by:

Gisela Wisskirchen, Manager, Medicare Administration
Lorrie McDaniel, Supervisory Reimbursement Specialist
Allie Ernst, Mgr, Data Processing Support
Tom Jones, Data Processing (Kings County)
Peggy Green, HCFA, Region X
Harry Savitt, HCFA, BDMS
Howard West, Mandex
Ben Duggar, SAIC

The program in Washington State is administered very differently from that in the other states visited, due to the decentralized operation of Washington Physician Service (WPS) as prime contractor. There are 13 Medical Bureaus which operate (usually on a county basis) under subcontract to WPS to actually process claims, interact with beneficiaries and providers, and make payments. Kings County is the largest of the Bureaus and also does all of the automated data processing for the other Bureaus.

1. History of HCPCS Implementation in Washington

The conversion was carried out on October 1, 1982 and was well supported by WPS. Prior to that date there were four different coding systems in use in the state for Part B --- two versions of CRVS, one Bureau used NABSP codes, but about 86 percent of claims were in CPT. Because of the different coding systems used, data processing was very cumbersome. Three computer runs were needed to convert the various codes such that they could be combined. WPS had proposed to HCFA that all Bureaus convert to CPT as early as 1975. Also, because most physicians use CPT, those Bureaus using CRVS or NABSP had to convert CPT to the CRVS or NABS, then if the data were to be aggregated across Bureaus, they had to be converted back to a common system.

Because of these pre-existing problems the Model B processing system in use already had a cross reference table built in which went from CPT to CRVS or NABSP codes. This system could handle five digit codes and modifiers. Thus, conversion to HCPCS should have been a great simplification of the date processing. It was, but there still were some problems in that not

all of the physician billing systems could accommodate alpha numeric instead of straight numeric codes. Those systems using packed fields, for example, required substantial modification.

Prior to the transition to HCPCS there was no EMC in Washington, but it now is up to about 7% and growing (some Bureaus are up to 18%). To facilitate implementation of HCPCS WPS distributed mini-lists by specialty.

Medicaid uses CPT-4, but does not have any alpha numeric codes, even for DME (have about 800 DME numeric codes). Thus, Medicaid must translate alpha numeric codes on the crossover tape to their own equivalent of "level 2".

2. Systems Considerations and Updates

Because the WPS system has the cross-reference file built in, it also can handle annual updates with minimal disruption. This also means that they can accept superbills which are precoded in the wrong system and have a mechanism for monitoring provider coding.

WPS implemented the 1985 HCPCS update about one month after it came out. The tape sent out by HCFA couldn't be used since they really need a list of the changes, not a revised tape (Appendix B of CPT-1985 is the type of information WPS needs). WPS experienced major difficulties in dealing with Level 2 codes which had been reassigned, since they carry the former codes & translations in the system, but now can't tell which way a reassigned code should go when it comes in on a bill (which version did the physician intend?). It is recommended that codes no longer used be "retired" for up to three years before reassignment.

Current volume is about 4.6×10^6 claims per year. WPS is a 100% BMAD tape carrier for 1984 data. A layout for the Master Procedure Code File appears in Attachment A and shows the full array of data items carried for each HCPS code.

3. Provider Coding

Because of the decentralized nature of Part B servicing in Washington there is close liaison with providers. Each Bureau keeps local providers advised on HCPCS changes, monitors their coding, and helps with review of proposed superbill coding. In general, providers in Washington do not use the HCFA 1500 -- instead use a WPS Medicare/Medicaid form (see Attachment B).

Thus, issues about the location of service code printed on the 1500 don't apply. Usually providers indicate location through a pnuemonic code (e.g. H for hospital, OV for office visit).

Providers with coding questions can call the local Bureau. Sometimes problems are referred to WPS, who has medical consultants for addressing these. Also, each Bureau has a medical director. On occasion the Washington Medical Association may be contacted, and then the question or concern is passed on to the AMA if it is a CPT problem.

Some provider coding problems are:

- RPTs indicate that the physical therapy codes are not suited for them (apply to physiatrists), so WPS has a number of level 3 codes for RPT use.

- Opthalmology and optometry services are covered by different codes for the same service --- some of the codes are only for opthalmologists, others can be used by either/or. The level 2 supply codes can be used by either group. WPS has had problems getting agreement so that they can publish coding lists in specialty manuals for EMC. The opthalmologists in Washington have agreed to use V codes rather than the CPT and have thereby "unbundled" their charges. However, since most opthalmologists refer their patients to the optometrist for supplies, few will actually use the V codes.

- WPS has a group working on the surgical pathology codes in order to get better uniformity of use. Code 88304 (a catch-all code covering gross and microscopic examination of presumptively abnormal tissues, uncomplicated specimen) is used too frequently in Washington, according to the pathologists.

- WPS has grappled with the problem of non-specificity in some of the CPT codes. For example, "repairing of lesions", code 11051 covers two to four lesions, 11050 covers a single lesion, and 11052 covers more than 4 lesions. For three lesions a physician could bill using 11050 plus 11051, or could use just 11051. Which is correct?

- Podiatrists have been instructed by their society to use 11750 (exision of nail and nail matrix, partial or complete) twice if more than one border of the nail is excised. WPS believes one use of the code covers all borders for a single digit.

- The J codes are regarded as too vague to be priced out. WPS would prefer to use the NDC codes. For injections they need to know the drug used in order to make a coverage determination. This makes for complex coding.

- WPS uses 9500x for antigen codes (the last digit gives the number of tests!).

4. WPS Coding and Processing

Claims are received at each Bureau where they are reviewed and entered using an on-line system tied into the Model B processor located in Kings County. There are extensive on-line edits. After a batch has accumulated centrally the system prices further edits, prepares queries, writes payments, and updates the history. Coding errors are considered to be infrequent with most prevented by the on-line edits. The QA system results show WPS to have a very low error rate, although some of the DEFRA related changes caused a spurt in errors. The reasonable charge tolerance edits are also likely to provide an indicator for picking up coding errors.

The larger bureaus do divide claims by specialty -- e.g. all surgery claims go to a particular examiner, all podiatry to another, etc. This increased specialization reduces flexibility in staffing, but probably does help with quality control.

At present about 85 percent of claims received are precoded!

The model B system handles up to two 2 digit modifiers. The type of service code is also an important determinant of what a code may mean. Surgery codes, for example, apply to the surgeon, or the anesthesiologist, or the assistant surgeon, depending upon type of service.

WPS prepares the instructions on new codes, develops training manuals, etc. but the Bureaus train their own staff to do the bill review and data entry. WPS also trains the trainers for the Bureaus. It is noteworthy that in spite of the small size of the staffs at some of the Bureaus and the small classes which may occur for claims examiners (some Bureaus may run a course for as few as 2 students), the costs of WPS Part B are favorable. Perhaps there are diseconomies of scale in Part B operations.

The computer system is tape oriented, so all files must be passed daily for updates. At present this means about 15 tapes are run each night and then backed up. Thus, there is much manual tape handling. Also, several smaller Bureaus send data by microfiche which are then updated and returned the following morning.

5. Anesthesiology Reimbursement

The anesthesiologist reports the surgeon's procedure code, then uses a type of service code to indicate anesthesia. Time units are reported in

15 minute blocks, entered in the "number of services" column. Special qualifiers are picked up as a second line item using the 9910X codes.

The Professional Affairs Committee is used to determine which special procedures are/are not included in the base unit value (e.g. insertion of Swan-Ganz catheter or use of arterial lines). For some procedures there is payment for separate billing for CVP, for others it may not be allowed.

The history file only shows one RVU figure for the anesthesia, but by knowing what the RVUs were for the Px reported one can deduce the time units. If extra units were allowed for an arterial needle, for example, this would appear in the total and confound the analysis. WPS does recognize certain patient status modifiers.

If a CRNA performs the anesthesia, this will not be indicated in the history, but the time blocks would be 30 minutes. There are 4 locality areas for determining the prevailing screen.

6. Other Concerns and Observations

- WPS regrets the deletion of bilateral codes since they had been eligible for separate reimbursement in Washington for years. Some private payers in Washington use the 1974 CRVS which allow 50 percent more for a second Px such as bilateral (150 percent of unilateral), another 25 percent if a third procedure is performed, 10 percent for a fourth, and 5% for a fifth. The bilateral code was easier to handle than the use of two separate codes.

- The critical care codes used to be procedure specific, but now are independent. The fees per hour in CCU have skyrocketed and there isn't enough detail to adequately control the use.

- It would be useful if HCFA would maintain and circulate a list of HCPCS codes not covered under Medicare. Right now each carrier must invent it themselves, then update it with each annual HCPCS update.

- Certain microsurgery is indicated by a special modifier (20) or by use of 09922, but also appears as a separate code for nerve repair in CPT-1985 with a note to add a code for the procedure (e.g. see 64830). What is the correct way to code microsurgery in the brain, for example? The same procedure can be billed three different ways!

- Codes for specimen collection also are confounded with the variations on cutdowns, venepuncture, etc. It is not clear which way to code.

- Opthalmologists in Washington want a special code for laser treatment.

- There are problems with ESRD coding -- for dialysis on an inpatient basis should the physician receive reimbursement? If he orders it, but it isn't done, would the physician still receive reimbursement? WPS believes that a routine hospital inpatient visit is not really much different than for an ESRD inpatient visit. However, there is a small reimbursement differential. Prolonged service or detention codes really should be allowed only when a difficult to administer procedure is performed (99150-99156). The CPT-1985 codes are easy to use but if the code required "acute-unstable" as a modifier, their use could be controlled until "acute stable" indicated patient improvement.

Washington Phys. Services

IBM

INTERNATIONAL BUSINESS MACHINES CORPORATION

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Printed in U.S.A.

PROPORTIONAL RECORD LAYOUT FORM

Revised 5/17/84
Revised 4/12/84

Application MASTER PROCEDURE CODE FILE Type of Records VSAM FB LRECL=435 By JUDY EDWARDS Date 8/18/82 Page 1 of 1

RECORD NAME AND REMARK

PROCEDURE CODE RECORD

Hex.	Dec.	Field
01–05	1–6	PROCEDURE CODE HCPCS CODE
06–0A	6–10	RECORD mod mod 1 2
0B	11	I P
0C–0F	11–16	MED RVU
10–13	16–20	ASA BASE
14	20	I C C
15	21	FLAT FEE
16–19	21–25	L P S
1A–1E	26–30	REFER TO NOTE.
1F–23	31–35	MODIFIER PRIMARY RANGE FROM PROCEDURE HCPCS CODE
24–28	36–40	TO PROCEDURE HCPCS CODE
29–2D	41–45	mod 1 mod 2
2E–32	46–50	MODIFIER SECONDARY RANGE FROM PROCEDURE HCPCS CODE
33–37	51–55	mod 1 mod 2
38–3C	56–60	TO PROCEDURE HCPCS CODE
3D–41	61–65	mod 1 mod 2
42–46	66–70	DIAGNOSIS 1 FROM
47–4B	71–75	TO
4C–50	76–80	DIAGNOSIS 2 FROM
51–55	81–85	TO
56–5A	86–90	DIAGNOSIS 3 FROM
5B–5F	91–95	TO
60–64	96–100	
00–04	0–4	
05–09	5–9	
0A–0E	10–14	
0F–13	15–19	
14–18	20–24	
19–1D	25–29	
1E–22	30–34	
23–27	35–39	
28–2C	40–44	
2D–31	45–49	
32–36	50–54	
37–38	55–59	
3C–40	60–64	
41–45	65–69	
46–4A	70–74	
4B–4F	75–79	
50–54	80–84	
55–59	85–89	
5A–5E	90–94	
5F–63	95–99	

Field layout:

PROCEDURE CODE DESCRIPTION LINE 1

PROCEDURE CODE DESCRIPTION LINE 2

PROCEDURE CODE DESCRIPTION LINE 3

PROCEDURE CODE DESCRIPTION LINE 4

INACT DATE

INACT HCPCS CODE | VREF mod 1 mod 2 | MAINT UP ID | MAINT DATE mm DD YY | PRINT SORT KEY PROCEDURE CODE HCPCS CODE mod 1 mod 2 SEQ #

Copy Book = MBT00016

DSN = VSAM.MB.PDLDE-MBCPT4.PROC

*Two numbering arrangements, each in hexadecimal and decimal notation, are shown. Select the arrangement and notation used by checking the appropriate box to the left.

†The number of forms per pad may vary slightly.

Fold to Here

Attachment A

HEALTH INSURANCE CLAIM FORM — WASHINGTON STATE

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM
Form Approved O M B -0938-0008

Attachment B

DO NOT STAPLE IN BAR AREA

[redacted]

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ INDUSTRIAL INS

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME AND ADDRESS

PHONE NO.

2. PATIENT DATE OF BIRTH

3. INSURED S NAME (First, Middle Initial, Last Name)

5. PATIENT'S SEX ☐ MALE ☐ FEMALE

6 INSURED S MEDICARE, MEDICAID or I D No (Include any Letters)

7. RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

8. INSURED'S GROUP NO (or Group Name)

9 OTHER HEALTH INSURANCE ☐ YES ☐ NO

Enter names of Policy holder and plan name & Address & Policy or Medical Assistance No.

10. WAS CONDITION RELATED TO. YES NO EMPLOYMENT YES NO ACCIDENT AUTO HOME SCHOOL OTHER.

11. INSURED'S ADDRESS (Street, City, State, Zip Code)

PHONE NO

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read Back before signing) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST PAYMENTS OF MEDICARE BENEFITS, EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

IGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 ONSET OF ILLNESS INJURY DATE

15. DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS. ☐ YES ☐ NO

16a. IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e g. public health agency)

I D NUMBER

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO CHARGES

23a. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE (Use ICDA-9)

1

4

5

23b PSDT ☐ INITIAL ☐ FOLLOW UP

FAMILY PLANNING ☐ YES

24 PRIOR AUTHORIZATION COMMENTS ☐ YES ☐ NO

SIGNATURE

24

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services or Circumstances) TOS	PROCEDURE CPT IV	CODE MOD	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G REMARKS	H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)

SIGNED DATE

26 ACCEPT ASSIGNMENT (Government claims only) (SEE BACK) ☐ YES ☐ NO

27 TOTAL CHARGE

28 AMOUNT PAID HEALTH INS

28a AMOUNT PAID PATIENT

29 BALANCE DUE

30. PHYSICIAN SUPPLIER SOC SEC NO

31 PHYSICIAN SUPPLIER NAME, ADDRESS ZIP CODE & PHONE NO

32. YOUR PATIENT S ACCOUNT NO

33. PHYSICIAN SUPPLIER EMPLOYER I D NO

REMARKS.

SITE VISIT REPORT
BLUE SHIELD OF CALIFORNIA
MEDICARE PART B

San Francisco, CA
July 25, 1985

The site visit took place in the Blue Shield Plaza building in San Francisco.
Attending the meeting were:

Arthur Meharg, Director, Medicare Administration
Kay Orton, Blue Shield
Joe Martini, Coordinator, Medicare Policy
Helen Oglesby, Asst. Vice President, Operations Support
Harry Savitt, HCFA
Howard West, Mandex
Ben Duggar, SAIC

Because all routine processing of Part B claims occurs elsewhere in California it was not possible to observe claims examiners at work. The following paragraphs highlight the information gathered and the HCPCS issues discussed.

1. History of HCPCS Implementation in California

Prior to October 1984 Blue Shield used a hybrid system which combined 1969 and 1974 CRVS codes. At that time EMC percentage was about 10%. Medicaid was using then, and continues to use a 1974 CRVS system. Blue Shield was accepting either 1969/1974 CRVS or CPT-4 codes for its private business.

Preparation of the providers for the conversion started in August 1984. Announcements were sent out to providers, and training was conducted in various locations around the state (Blue Shield is the Part B carrier for all except 7 counties in southern California which are covered by Occidental). There was excellent turnout for the training sessions. Publicity concerning the transition had begun about twelve months earlier, but few providers ordered CPT-1984 until September 1984. The AMA quickly

ran out of copies, so some of the providers were most agitated. California Blue Shield then published a bulletin which listed the base code (1969 CRVS) and the corresponding HCPCS code. Although this was necessary for provider conversion, the AMA was upset and feels it was an infringement. Separate training sessions were run for DME providers.

The actual conversion occurred on October 1, 1984 and was quite disruptive to the claims processing operations. Because Medicaid did not convert, this caused problems for the crossover claims. Medicaid was provided with a copy of Blue Shield's conversions so that they can convert the crossover tape from HCPCS back to CRVS.

In preparing for the conversion Blue Shield developed a large number of local codes (about 204), but HCFA would only approve 45 of these after much discussion. Blue Shield still feels it needs at least 43 more. Because of Medicare coverage changes and unique billing for services needed due to state legislation they need more local codes (e.g., the administration of drugs by an EMT in an ambulance can be billed separately from the ambulance service, there also is separate billing for the 8 percent tax on air ambulance service -- both need codes).

2. System Changes and Handling Annual Updates

Blue Shield used a conversion tape to shift from old codes to new. This conversion tape was also automated for examiners during the first 6 months after the conversion.

Because of the similarity of 1974 CRVS and CPT, the system changes required were minimal. The system does carry up to two 2-digit modifiers, but can't handle any more if required in future changes.

The 1985 updates were completed on April 1, 1985. Several problems were encountered in the updating. First, the update tapes were unreadable. Blue Shield of California then went to Blue Shield of Colorado to get something they could read after twice failing to use HCFA tapes. In the future they would prefer to receive a tape containing only the changes. A second problem arose because HCFA used a prior code for a new item in Level 2.

3. Blue Shield Coding

At present about 16 percent of claims are EMC and are precoded. Of the hard copy claims received, about 85 percent are precoded, most having both codes and narratives. Thus, the coding load on Blue Shield examiners is light and coding aids are not a high priority. All claims are received in Chico, CA where they are microfilmed and some are entered. Some of the claims are trucked to the Marysville and Colton offices for data entry. All processing is on-line, with only the DME claims broken out for handling by a special group. Provider and medical review are all performed in San Francisco.

Many providers are still using 1500s which they received free. As the supply dwindles and providers have to buy them it is expected that the use of super bills as an alternative may grow (it is already a significant volume). Because Blue Shield for its private business and MediCal both give out free billing forms (4359) the use of these forms is also likely to grow. There is also concern as to whether the shifts in billing forms may adversely affect assignment.

Blue Shield processes about 53,000 claims each day, so those needing coding number about 5000-7000/day. Blue Shield developed its own coding manual for use by the examiners. This manual is covered during the training of new examiners. At the time of the HCPCS conversion the on-line system did flash up the list of narratives for coding options in response to a CRVS code entry. This coding aid is still in the system but seldom used any more. Because of the similarity between 1974 CRVS and CPT for common procedures, training requirements were minimal, and there was no need to develop "short lists" or "cheat sheets" for the examiners. The one big area of difference was for DME and so a special group of examiners have been trained to handle all DME claims.

4. Provider Coding

Blue Shield keeps a steady flow of information going out to the providers on coding updates, changes, and clarifications. These are published in the monthly bulletin which goes to all providers. Providers with coding problems may contact any of a number of individuals, but if the problem remains unresolved, it generally ends up with Joe Martini.

Joe sometimes refers the caller to the AMA and may, on occassion, query the HCFA Central Office on Level 2 problems. Providers are strongly encouraged to send the codes and this has been very successful. If MediCal would also change to HCPCS, most of the remaining uncoded claims would disappear.

5. Anesthesia Reimbursement

Reimbursement of anesthesiologists in California for Part B services is controversial and there are only 5 anesthesiologists who accept assignment for all patients (most will selectively accept assignment). Patient Status modifiers are recognized and result in extra relative value units if P3 or more, and if not already included in the surgical procedure code. For most procedures the use of arterial needles or insertion of a Swan-Ganz catheter is included in the base units. If an anesthesiologist has more than two modifiers to report on an EMC submission, he must submit additional "justification" since there is only a 9 digit field in the tape format.

The actuarial department of Blue Shield was reported to have done a study on use of the ASA codes. The findings were that the codes would result in from 25 to 35 percent cost inflation. They also noted that it would be impossible to do "coverage" checks and that legitimate occurrences of multiple trips to the OR by a patient could result in the anesthesiology claims being suspended as "duplication of billing".

6. Blue Shield Concerns About HCPCS

Because of their initial bad experience in attempting to obtain approval for local codes, Blue Shield is reluctant to assign them now even when apparently needed. As a result, many procedures are coded 99999 and must be manually priced each time. This slows the processing and increases the proportion of claims held in the suspense file. For example, in California fluoroscopy time is often used and they desparately need a local code. At the time of the conversion to HCPCS Blue Shield noted that the Conversion Manual required them to hold the line on inflation when making the conversion. However, when they assigned local codes for partial performance of an existing HCPCS code, the Central Office rejected it.

California tends to be at the forefront of development of new procedures. However, it takes about 2 years for a new and popular procedure to be reflected in CPT. Thus, Blue Shield must use more local codes.

Another continuing problem with Level 3 codes has to do with Medicare benefits changes. At the time the benefit change is effective, the carrier often must assign a local code. However, about a year later HCFA assigns a national alpha numeric code in Level 2. Thus, the carrier has to turn the examiners and the providers around twice on the coding for the changed benefit. It would be very cost effective for HCFA to centrally assign the Level 2 code to become effective concurrent with the benefit change date.

With respect to use of Level 1 (CPT) versus use of Level 2 and/or Level 3 codes, there are problems when there is a choice. It has been Blue Shield's impression that if there is a choice, the provider should not use Level 2, but rather Level 1. In many cases, Blue Shield's previous coding scheme contained one code which described a combination of services (i.e., urinalyses and CBC) which is now unbundled by Level 1 and/or Level 2 codes. This unbundling has an inflationary effect, yet Blue Shield must now use Level 1 codes even if the combination code was previously accepted by providers and reimbursed at a lower level.

The CPT section on dialysis is very hard to work with, with procedure codes varying based on the weight of the patient. Blue Shield would rather use Level 2 instead, but with the option of adding 1-2 local codes. This change has a large potential for cost containment.

With respect to updates:

- In 1985 Blue Shield only had 60 days but really needs 90-120 days to do it both in an orderly fashion and correctly.

- It would help if HCFA would distribute a clear rationale and action to go with each code change (e.g. the colostomy supply issue) since each carrier has to develop these on their own right now.

- Blue Shield doesn't feel it would save much to organize a carrier group for collective preparation of the edits or contingencies for each changed code (additions, deletions, or definition changed). The edits have to jibe with how physicians in that area bill for service, where they do the service, and how each carrier reimburses for it before the change could be put in the system.

Other concerns and observations:

- Quality assurance audits on EMC records by providers focus on previously identified problems with potential fraud and abuse, so are not a random sample which would be good for assessing coding quality.

- The DME change cost much much more than the central office estimate ($70K/carrier).

- Do not consider coding diagnoses from Part B bills because it would be costly and of poor quality/utility.

APPENDIX B

COMPREHENSIVE SYSTEM PLAN

FOR HCPCS CODE STANDARDIZATION

May 1, 1985

Prepared Under Contract HCFA 500-84-0036
by Mandex, Inc. (prime contractor)
and JRB/SAIC (subcontractor)

Howard West, Project Director
Ben Duggar, Senior Scientist

Harry Savitt, Project Officer
Office of Information Resources Management
(BDMS, HCFA)

1. SUMMARY

The HCFA Common Procedure Coding System (HCPCS) was developed to encourage movement toward use of a single coding system for all fee-for-service reimbursement activities. The concept has been well accepted, major agreements have been negotiated to make feasible the incorporation of a pre-existing coding system as a base, and implementation for Medicare, Medicaid, and other payers is advancing rapidly. However, to continue the national trend towards universal acceptance of HCPCS and to achieve the anticipated benefits the system must be maintained and supported.

At present there are only anecdotal data concerning the accuracy with which providers and carriers select and report HCPCS codes. Although isolated reports have been received concerning deficiencies in the indexing of code lists, until now there has been no systematic documentation of the extent of the problem nor attempts to create an index or set of indexes which will meet the wide array of user needs. The implementation of HCPCS among the states has been subject to only limited central oversight, and there are instances of duplication of codes and other aspects of non-uniformity which will impair the ability to aggregate information across the states.

To address these problems a comprehensive system plan for HCPCS code standardization has been developed. The standardization system consists of the following elements:

1. Development of complete indexing of HCPCS codes, including preparation of multiple specialty and partial indexes.

2. Implementation of a system of index maintenance which is responsive to user requests for clarification, to new code requests, and to provision of assurances of unique qualities associated with local codes.

3. Establishment of a baseline of current coded data quality, together with identification of factors which encourage or inhibit data quality, and the potential for intervention.

4. Development of techniques and systems for data quality monitoring and feedback.

5. Development of specialty coding manuals.

6. Assuring the availability of training materials for coder use.

7. Testing and dissemination of findings concerning various available coding aids.

8. Establishment within HCFA of a central clearinghouse and dissemination point for HCPCS standardization materials.

The standardization system is currently being developed and will be fully implemented by FY 1986. Indexes are now under development with external review and test scheduled for the fall of 1985 and distribution to carriers by December of 1985. Indexes will be monitored and updated semi-annually thereafter. A study of HCPCS coding accuracy is about to begin, with results expected by the end of 1985. Work has already begun on techniques for linking Medicare Part A and Part B bills and testing for consistency between HCPCS and ICD-9-CM codes for surgical procedures. Test results should be available by August 1985. Specifications for a HCPCS data quality monitoring system are being developed and a demonstration will be arranged for fall of 1985. Plans for establishment of the clearinghouse are being drawn up and the initial dissemination of materials should coincide with completion of certain of the HCPCS indexes.

It is anticipated that these efforts to standardize HCPCS codes and their utilization will accelerate the conversion to HCPCS by remaining payers, facilitate the advance of electronic billing, produce better utilization and cost statistics, provide greater control over the escalation of benefit payments through code fragmentation, and provide more uniform interpretation of coverage and reimbursement policy, better utilization review, and enhanced management of the Medicare and Medicaid programs.

2. BACKGROUND

2.1 Development of HCPCS

During the 1970's a number of coding systems were in use for fee-for-service reimbursement. The National Association of Blue Shield Plans (NABSP), for example, had their own coding system. The American Medical Association (AMA) continued to revise and update their Physician's Current Procedural Terminology (CPT), issuing CPT-3 in 1973 and CPT-4 in 1977. CPT was first issued in 1966 to replace the earlier Standard Nomenclature of Diseases and Operations. The California Medical Association modified and expanded the California Relative Value System (CRVS) until forced to halt by a Federal Trade Commission consent decree. In addition, payers used differing editions of the same code system, often with the addition of special codes to meet their own unique needs. The resulting confusion of codes served to discourage provider coding, inhibited electronic billing, and often prevented meaningful aggregation and comparison of utilization and cost data across separate states and districts. The Medicare Directory of Prevailing Charges, 1983, for example, notes that "because of differences in coding systems it may sometimes be necessary to consult directly with the carrier for clarification." This is in spite of the fact that the Directory only presents data for 110 procedures or durable medical equipment.

In the late 1970s HCFA, in consultation with a combined Carrier/State Agency Technical Advisory group, initiated the development of HCPCS. In February 1983 the Federal Government and the AMA reached an agreement which permitted the development of HCPCS using the fourth edition of the "Current Procedural Terminology" (CPT-4) as the base. Because Medicare and Medicaid cover a variety of services other than those provided by a physician, the CPT codes were inadequate for Medicare and for Medicaid in some states. The HCPCS expansion of CPT-4 provides for a block of codes specific to Medicare and Medicaid needs, a block of codes for local use, and provides an orderly process for handling requests for new codes and other modifications.

HCPCS was tested in South Carolina in 1980-81 and shown to not produce unwarranted cost escalation. Since 1983 HCPCS has been implemented, or is in the process of being implemented, by about 95 percent of all Medicare carriers, a somewhat smaller proportion of all State Medicaid agencies, and by a number of private third

party payer organizations. It is anticipated that all Medicare Part B carriers and most Medicaid agencies operating a certified Medicaid Management Information System will implement HCPCS by FY 1986.

When a Medicare carrier is ready to implement HCPCS it first submits a list of the codes and descriptions to HCFA for approval. Requests for new codes for physician services are transmitted directly to the AMA for consideration by a group representing the various medical specialties and HCFA. In some cases these requests can be handled by clarifying the scope of an existing code, while a new code may be justified in other cases and included in a future update. Although the AMA has an index for CPT-4, there is no index for the other parts of HCPCS. Also, there is no methodology for monitoring the local use codes, or for expanding the index to HCPCS as new codes are added, clarifications made, or as new synonyms or eponyms come into common usage. Also, only anecdotal data exist as to the accuracy with which services are coded by providers or payers, and it is unknown whether computer based files maintained by the carriers accurately represent the codes originally on the bills or derived from them.

2.2 Potential Sources of Non-Uniformity

There are a number of potential sources of non-uniformity in HCPCS data. Because the interventions to address these various sources differ, it is critical that each source be individually assessed. The major sources are considered to be:

- The CPT code system itself, including
  - --duplications within CPT-4
  - --ambiguities in the CPT index
- The manner in which HCPCS has been implemented
  - --duplications between level 1 and level 2 codes
  - --duplications between level 3 and other level codes
  - --control of level 3 code establishment
  - --lack of index for level 2 codes or for combined levels 1 and 2
- Poor coding quality by providers due to
  - --inadequate index
  - --absence of monitoring/feedback to detect and correct systematic errors
  - --lack of training in use of HCPCS
  - --adverse economic incentives

- Poor coding quality by carriers due to

  --inadequate index
  --incomplete narrative on bills
  --lack of training in use of HCPCS
  --systematic coding errors and absence of effective monitoring/feedback

- Machine processing of bills (both during preparation by providers and review and payment by carriers).

The problem of duplications within CPT, and ambiguities in its index, can be addressed through the AMA's planned annual revisions. However, the identification of specific codes, definitions, and index entries requiring change is a major undertaking. Similarly, the overlap between HCPCS level 2 and CPT codes, without a clear difference in definition and indexing, detracts from uniformity. This is further confounded by insufficient controls on level 3 code establishment.

Poor coding by providers is suspected, but measurements are not available. Training, monitoring, and availability of better indexing are likely to be effective, however. Coding by carriers will also be responsive to these interventions, although the audience and manner of dissemination will be greatly different for carrier's as opposed to providers' staff.

2.3 Components of a Comprehensive System

Given the above cited needs for standardization, preliminary evidence of problems, differing sources of data quality deficiencies, and scope of the required interventions, a comprehensive approach is recommended. This comprehensive system will:

- Begin with an assessment of current quality, both of the coding system and current index, and of the coding being performed.
- Include an assessment of the relative contribution of various factors to quality such that priorities can be assigned for interventions, that policy changes can be used to prevent future problems, and in order to identify states or carriers where further study and monitoring will have the greatest payoff.
- Provide as soon as possible an index or series of indexes together with identification of duplications and ambiguities in the code system and definitions.
- Establish a comprehensive but restricted system for update and maintenance.

- Develop and disseminate training materials and information on coding aids.
- Provide techniques for monitoring and feedback of data quality.
- Establish a central source of information and coordination concerning coding issues, code or definition changes, training materials and aids, index update and clarification, and data quality.

These components are interrelated, but their development is not necessarily sequential. The plan for development and implementation of each component is described in chapter 3.

2.4 Recent Developments

The Congressional mandate that HCFA provide recommendations for a physician prospective payment system (PPS) by July 1, 1985 leaves little time for addressing data quality issues concerning physician services and the existing Part B data base. A likely scenario would consist of the testing of several alternative PPS configurations in FY86 with recommendations deferred until 1987-88. High quality HCPCS data would be essential to both the conduct of such a test, and to comparisons with experience in non-test areas.

A second area of concern relates to the hospital PPS system using DRGs. The DRG for a patient is based on coding of diagnoses and procedures in ICD-9-CM, but ICD-9-CM surgical procedure codes tend to have less detail than do the corresponding HCPCS codes. A study of the relationships between HCPCS codes for the operating physician and DRG groupings for the hospital is needed to understand one potential alternative for improving homogeneous groupings of patients. If a crosswalk between the two coding systems can be developed, linked records may also be useful for avoiding or calling forth PRO reviews.

A third area of rapid change is that dealing with electronic media claims (EMC). The cost savings to Medicare and Medicaid of EMC is large, but EMC progress has been slow in many carrier areas. At least part of the delay is related to provider concerns about coding, concerns which could be ameliorated by support for high quality coding and the standardization of HCPCS among most payers, billing services, and computer based packaged billing systems.

3.1 PLAN FOR DEVELOPMENT AND DEMONSTRATION

3.1 Assessment of Current Data Quality

This component is essential for establishment of priorities for interventions, for documenting reasons for concern, to establish a baseline against which change can be measured, and as a means of identifying factors which contribute to or inhibit data quality performance. Assessment will be carried out through two concurrent approaches:

- o Review of HCPCS implementation by the carrier in several states, giving particular attention to the completeness of codes listed, the extent of duplication within and between levels of HCPCS codes, the mechanisms which were put in place to facilitate implementation and respond to queries, and the pre-existing operating environment.
- o Validation of a sample of bills, both provider coded and carrier coded, in each of six states.

It is anticipated that answers to the first part, the implementation process, may help to "explain" the actual data validation findings.

As a first step six carriers will be recruited for participation in the study. Preliminary selection of carriers includes:

- Connecticut General
- BS of Maryland
- BS of Florida
- Medical Mutual Ins. of Indiana (BS)
- Blue Shield of California
- Washington Physicians Service (BS)

Thus, the list represents six HCFA Regions, includes a wide range of carriers based on volume of claims, range of assignment rates, range of EMC, and experience with HCPCS. One commercial and five Blue Shield plans are represented.

Through a combination of site visits, review of available information from the regional offices and carriers, and the selection and validation of a sample of provider and carrier coded bills a profile will be developed for each of the participating study carriers. This profile will focus on the following items:

- HCPCS Implementation Environment

  --Preexisting codes used
  --Annual processing volume and trends (assignment rate, proportion of assigned bills which are not precoded, proportion of unassigned bills for which submitted documentation includes codes, EMC)

- The process followed in the state for implementing/transitioning to HCPCS

  --Use of training sessions
  --Dissemination materials
  --Advance notice and timing
  --Data quality methods used during transition
  --Use of abbreviated code lists

- Internal Coding Operation by Carriers

  --Assess the coding techniques being followed, including whether indexing aids, mini-lists, etc. have been developed
  --Discuss the workload and whether evaluation of the impact of an improved index on coding productivity would be feasible
  --Determine if there currently is a division of labor based upon physician specialty, major providers, source of bill or claim, etc.

- Processing of HCPCS Codes by Carriers

  --Data entry decisions
  --Internal edits (valid code, physician specialty cross check, logical consistency with other items)
  --Actions taken when a code fails an edit
  --Historical yields on edits

- Accuracy Rates for HCPCS Codes

  --Provider coded bills, by specialty
  --Carrier coded bills, by specialty of provider.

Sites have been tentatively selected and only BPO clearance is needed before initial site visits are arranged. A report analyzing and describing the findings will be available by January 1986.

It is anticipated that the analyses of data accuracy will indicate in a very general way the types of implementation environment for HCPCS most prone to subsequent data quality problems. Sites with unusually good quality data will be used to develop hypotheses about how to avoid future data quality problems, and to suggest effective interventions for improving data quality in other states.

3.2 Index Development

Separate indexes will be developed for each of the major CPT-4 sections and for HCPCS level 2 codes. The resulting separate indexes for the CPT-4 sections will then be combined and all duplicate codes or ambiguous definitions identified. The resulting index will be a self-explanatory index in which the user is led through the use of key words to select a single code for each descriptor, or to realize that more than one code must be used. The indexes will be distributed to review groups from the AMA CPT-4 committee, other various medical specialties, and to selected HCFA and carrier staff. A test use by several providers in each of the medical specialties will also be sought.

The HCPCS level 2 index will then be merged with the level 1 index to identify overlap in definitions. Duplications and overlaps will be analyzed and recommendations provided to HCFA for requesting revisions to CPT and/or for modifying or clarifying level 2 definitions or instructions. Indexes will be ready for test by the end of 1985.

3.3 Index Maintenance and Dissemination

New code requests and committee response, assignment of level 3 codes, and requests for index or code definition clarification will be monitored, documented, and used to develop semiannual index updates. New code requests, for example, may be turned down by the CPT committee, but the request would still trigger an index entry or clarification note to assure uniformity of use elsewhere. Each index update will be distributed in multimedia format to a comprehensive distribution list of carriers and state agencies. It is anticipated that the HCFA central clearinghouse will handle distributions.

The first major distribution of HCPCS indexes is planned for December 1985 with updates distributed periodically thereafter.

3.4 Data Quality Monitoring and Feedback

The various systems and procedures used by Medicare carriers, Medicaid Intermediaries or State Agencies, and other payers for edit review of HCPCS codes has not been centrally documented. Information collected from the carriers participating in the assessments described in Section 3.1 above will be used as examples for illustrating current practices. Working with these carriers, a more comprehensive set of edits and profile reports will be developed for both carrier and HCFA Central Office use. This will take the form of an automated system for bill review focusing strictly on coding accuracy and patterns of code use. Through the test use of this system we will develop provider, specialty group, carrier area, and Regional profiles of code utilization. These data will then be used to develop specialty coding manuals (see Section 3.5), for preparation of training materials (see Section 3.6), and for identifying nonnormative patterns of code use.

Working with one or two carriers, the feedback reports from the HCPCS monitoring system will be used to trigger focused training for carrier coding staff, the distribution of coding aids or training materials to providers with unexpected code use patterns, and informational releases to the professional community. These interventions will then be monitored to determine if code use patterns subsequently change.

A further use of the monitoring system will be for centrally reviewing and tabulating code usage for sample bills submitted by carriers. Use of individual codes and groups of codes can be tabulated and analyzed to determine:

- Which HCPCS codes are never or seldom used
- Which codes meet most of the needs of the various medical specialties or provider categories
- Whether patterns of code use within medical specialties vary between carrier areas or by region
- Whether any of the carriers are improperly reporting codes (level 3 codes, non-existent codes, illogical codes) and, if so, the extent of such reporting.

It is anticipated that the data quality monitoring system will be ready for demonstration use by early 1986.

3.5 Development of Specialty Coding Manuals

Using the partial indexes developed earlier (Section 3.2) and code utilization pattern data broken out by specialty (Section 3.4) we will develop abbreviated coding manuals for selected medical specialties. Such manuals should cover from 96-99 percent of the codes used by the specialty group, depending upon the actual number of different codes normally used. We will study the utility of such manuals to meet increasing proportions of coding needs as a function of increasing size and complexity of the manual. Based on these tradeoffs and the total volume of affected providers and claims volume, five specialty groups will be identified, cutoff criteria adjusted, and unique coding manuals prepared. These manuals will be distributed on a test basis to a sample of each specialist through their national organization and/or through the carriers in several locations. Code frequency use will be monitored before and after, up to nine providers will be queried by phone to assess user response and collect suggestions for manual improvement. The national organization for each specialty will also be asked to suggest improvements.

3.6 Preparation of Training Materials for Coder Use

Based on the experiences with each of the preceding standardization components, requirements for training of provider and carrier coders will be refined, the available training materials collected and reviewed, and new materials developed where gaps are detected. These materials will be disseminated to carriers and others through the HCPCS Central Clearinghouse (Section 3.8). It is anticipated that training material development will commence in October of 1985 and continue through winter of 1985-86.

3.7 Assessment of Coding Aids

A number of commercial products are available to assist with CPT or HCPCS coding. These range from the handy list of check-off codes used on preprinted billing forms to the computer based code index offered by several vendors. Widely used coding aids will be checked first to assure that they lead to accurate and complete coding. Assessment results will be prepared and provided to the vendors and to the clearinghouse. As new coding aids appear on the

market, samples will also be checked. In addition, as HCPCS codes are revised certain commercial coding aids judged to produce accurate coding will be rechecked to be sure that they continue to be current.

This activity will begin in mid 1985 and continue through mid 1986.

3.8 Operation of Central Clearinghouse

A Central point of contact is needed which will:

- Maintain status reports on code change requests.
- Inventory coding indexes, manuals, and other materials to be disseminated as part of the code standardization effort.
- Handle phone inquiries on coding problems, ambiguities in the index, and identification of duplications across HCPCS code levels.
- Handle mailings to qualified receivers of index updates and special materials.
- Serve a liaison function with other clearinghouses to insure wide awareness of code standardization materials and coding aids.

As part of the comprehensive code standardization effort implementation of such a clearinghouse is planned. The clearinghouse will initially distribute a monthly list of new accessions, with conversion to a quarterly or semi-annual list as the developmental activities are compelted. Periodic distributions to a HCFA approved list of recipients will be made. Requests from providers and other organizations for specific items will be honored after approval by the HCFA Project Officer. The clearinghouse will be organized in the fall of 1985 and be prepared to distribute the HCPCS indexes as they are developed.

3.9 Assessment of Anesthesia Reimbursement Alternatives

The AMA's CPT - 1985 contains 13 pages of codes, relative values, and modifiers for use in describing the value content of anethesia services. Many third party payers reimburse anesthesiologists based on this relative value concept. However, Medicare Part B usually reimburses for anesthesia services by tieing the reimbursment directly to the surgical service code plus a time unit modifier. The approach used by Medicare has been criticized by the American Society of Anesthesiologists (ASA) as not being an accurate reflection of the services rendered by the anesthesiologist. ASA has petitioned HCFA to adopt the CPT-1985 Anesthesia Section as part of HCPCS, and to use it for

reimbursement purposes. HCFA's concern is primarily budgetary in that any change in coding which increases the total costs to Medicare represents unnecessary inflation. However, HCFA has indicated to ASA that it is willing to study the impact of anesthesia coding alternatives and to consider study findings before making policy decisions.

In late 1984 ASA proposed to HCFA that the ASA undertake a study to demonstrate budget neutrality between the presently used coding and the proposed new coding system. The ASA study design called for recoding a representative sample of Medicare Part B paid claims submitted by anesthesiologists and then comparing the reimbursement which would have resulted with the actual level paid. Because of the pre-existing plans within the current HCPCS code Standardization Study to collect and analyze Part B coding reliability and related carrier practices in six states, BPO requested that BDMS consider addition of a component to this ongoing study to specifically address the ASA issue.

The BPO/BDMS discussions with ASA representatives have pointed out that many physicians other than anesthesiologists currently receive reimbursement for anesthesia services and should be included in the study. Also, because of PPS there are dramatic shifts in surgical rates by type of procedure and by settings. Thus, a simple retrospective study may limit utility for projecting impact on future expenditures. Also, if among settings and procedures there were well defined "winners" and "losers" resulting from a shift in coding it might be appropriate to provide for specific "adjustments" as part of any decision to change the coding system used. Consequently, a more complex research design is needed.

Design of the anesthesia coding comparison is currently under development. Issues and problems which must be addressed include:

- Retrospective analyses must deal with portions of the anesthesia being covered under Part A and portions under Part B.
- In order to use carrier history files for recoding both the "base" unit and "time" units must have been retained in disaggregated format.
- The severity modifier will not be available in the carrier history file.
- A prospective study design will require that the anesthesiologist either wait for the matched bill from the surgeon (to determine coverage of the procedure) or addition of the present as well as proposed codes to the same bill (dual coding).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JAN 22 1986

From Director
Office of Information Resources Management, BDMS

Subject Report on Site Visits

To See Below

The contract that the Office of Information Resources Management, BDMS, has with Mandex, Inc., is entitled Coding Standardization. Four tasks are being carried out concurrently. These tasks are:

1. develop a HCPCS Index;
2. link Part A data with Part B data, with testing of adapters for DRG formulation;
3. evaluate the ASA anesthesia codes for HCFA reimbursement; and
4. provide a system for HCPCS maintenance and monitoring.

In the performance of these tasks the contractor conducted six site visits. The attached report represents an interim summary of the observations and the contractor's tentative recommendations.

The report is being circulated for informational purposes to components and staff who have expressed an interest in the progress of the contract. If you or your staff has any comments or questions, please contact the project officer, Harry Savitt, at extension 76322.

John C. Parmigiani

Attachment

Addressees:

Director, Office of Professional and Scientific Affairs
Director, Office of Program Operations and Procedures, BPO
Director, Office of Reimbursement Policy, BERC
Director, Office of Coverage Policy, BERC
Director, Division of Carrier Procedures, OPOP, BPO
Director, Division of Medical Services Coverage Policy, OCP, BERC
Special Assistant to Deputy Administrator, OA
Director, Division of Reimbursement and Economic Studies, OR, ORD

cc: Regina McPhillips
Michael McMullen
Louis Hogan
Walter Schauermann

received 1/23/86